North Carolina Industrial Commission

Medical Rehabilitation Nurses Section Referral Form

REFERRAL SOURCE

Name _____ **Company** _____ **Date** __/__/20__
Address _____ **City** _____, **State** __ **Zip** _____-____
Telephone (___)___-____ **Fax** (___)___-____
REASON FOR REFERRAL/SPECIFIC CONCERNS _____

INJURED EMPLOYEE

Name _____ **IC#** _____ **SS#** ___-__-____
Address _____ **City** _____, **State** __ **Zip** _____-____
County _____ **Telephone** (___)___-____ **Fax** (___)___-____
Date of Injury __/__/____ **Type of Injury** _____
Physician's Name _____
Address _____ **City** _____, **State** __ **Zip** _____-____
Telephone (___)___-____ **Fax** (___)___-____

EMPLOYER

Name _____
Contact Person _____ **Title** _____
Address _____ **City** _____, **State** __ **Zip** _____-____
Telephone (___)___-____ **Fax** ___)___-____

CARRIER

Name _____
Claims Representative _____ **Claim #** _____
Address _____ **City** _____, **State** __ **Zip** _____-____
Telephone (___)___-____ **Fax** (___)___-____
Defense Attorney _____ **Telephone** (___)___-____ **Fax** (___)___-____
Plaintiff Attorney _____ **Telephone** (___)___-____ **Fax** (___)___-____

ASSIGNED REHABILITATION PROFESSIONAL (if involved)

Name _____ **Company** _____
Address _____ **City** _____, **State** __ **Zip** _____-____
Telephone (___)___-____ **Fax** (___)___-____

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